MOBILITY EVALUATION FORM WHEELCHAIR

(Fee-for-Service (FFS) Program Only – Not for Managed Care Program Use)

Pursuant to He-W 571.05(c), requests for all wheelchairs, scooters, and customized strollers must (in addition to Form 272D) include a completed Form 272M, "Mobility Evaluation Form Wheelchair"

This evaluation must be completed by a New Hampshire licensed Physician, Occupational Therapist, or Physical Therapist specializing in rehabilitation medicine. Evaluator must have a broad knowledge of the various seating systems and wheelchairs available in today's market. **NOTE:** Requests for standard/non-customized manual wheelchairs do not require the completion of this form by a Physician or OT/PT; a Rehabilitation Specialist may complete the form.

*****PLEASE PRINT OR TYPE ALL INFORMATION***(all fields are required)**

RECIPIENT INFORMATION

RECIPIENT NAME: _____ **DATE OF BIRTH:**_____

RECEPIENT HEIGHT: _____ **RECIPIENT WEIGHT:** _____

RECIPIENT MEDICAID ID #: _____**DIAGNOSIS CODES:** _____

ALTERNATE INSURANCE: NAME OF PLAN _____

PROVIDER INFORMATION

DATE OF EVALUATION: _____ **CONTACT PERSON:** _____
TELEPHONE #: _____ **FAX #:** _____
EVALUATOR NAMAE: _____ **EVALUATOR MEDICAID ID#:** _____
PERFORMING FACILITY: _____ **PERFORMING FACILITY MEDICAID ID#:** _____

DIAGNOSIS (WRITTEN, NOT CODE) **Primary:** _____
Secondary: _____

If this recipient has had multiple seating systems in the past three (3) years, or surgical procedures are anticipated, or growth or physical deterioration may limit recipient's ability to utilize the proposed seating system for less than five (5) years, then the recipient must be evaluated for an "adjustable growth" seating system that would accommodate any foreseeable changes.

CURRENT AMBULATORY STATUS

Please address the following: Would the recipient be confined to a bed if a wheelchair were not provided? Is the recipient able to use a walker, cane, or walk with assistance? What is the distance the recipient is able to ambulate without assistance?

MEDICAL HISTORY

Please provide dates and names of recent surgical procedures and/or hospitalizations as well as other relevant information.

CURRENT SEATING SYSTEM

Make: _____ **Model:** _____ **Age/Condition:** _____

PROBLEM WITH CURRENT SEATING SYSTEM:

_____

_____

_____

_____

PLEASE COMMENT ON RECIPIENT'S:

Vision: _____

_____

Cognition: _____

_____

Ability to Communicate: _____

_____

_____

Daily Activity Level: _____

_____

_____

Mobility Evaluation (strength/tone/contractures etc.): _____

_____

_____

_____

Anticipated Surgical Procedures/Orthotics: _____

_____

_____

_____

Other Special Considerations: _____

_____

_____

_____

PLEASE INDICATE WHICH LESS COSTLY WHEELCHAIRS/SEATING SYSTEMS HAVE BEEN CONSIDERED AND WHY THEY WOULD NOT BE APPROPRIATE TO MEET THIS RECIPIENT'S NEEDS. (attach additional comments as necessary):

_____

_____

_____

_____

_____

_____

TO BE COMPLETED BY PERSON PERFORMING THE EVALUATION

THE FOLLOWING OPTIONS ARE MEDICALLY NECESSARY:

	Option	Justification
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____
11.	_____	_____
12.	_____	_____
13.	_____	_____
14.	_____	_____
16.	_____	_____
17.	_____	_____
18.	_____	_____

RECOMMENDED CHAIR

Make: _____ Model: _____

Check all that apply. Indicate N/A if not applicable:

- ☐ Will allow access to recipient's home
- ☐ Will allow access to school/place of employment
- ☐ Will meet van/bus/other transportation methods recipient currently needs
- ☐ Will meet recipient's mobility needs
- ☐ Potential growth of recipient has been taken into consideration in selecting the size of chair so that it may provide at least **five (5) years of use**
- ☐ Recipient's caregivers are familiar with care /maintenance/operation of this chair
- ☐ Recipient has demonstrated proficiency in the safe operation of this chair
- ☐ Less costly chairs have been ruled out as inappropriate
- ☐ This chair will accommodate recipient's respiratory equipment and other special needs

SUMMARY / COMMENTS

_____

_____

_____

_____

_____

_____

_____ _____

Signature of physician, licensed therapist completing the evaluation Date

_____

Printed name of physician, licensed therapist completing the evaluation

INDIVIDUALS PRESENT DURING EVALUATION:

1) _____ Representing/Relationship to recipient:

_____

2) _____ Representing/Relationship to recipient:

_____

3) _____ Representing/Relationship to recipient:

_____

4) _____ Representing/Relationship to recipient: _____

RECIPIENT, PARENT OR LEGAL GUARDIAN (please check the statement that applies)

☐ I **accept** the recommendations for the make, model and options of the equipment being requested and acknowledge that the safe operation and benefits of the equipment's options and features have been fully explained to me. I have no questions or concerns regarding the recommendations made.

☐ I **do not agree** with all of the recommendations and I request changes based on the following:

_____

_____

_____ _____ _____

Signature of Recipient/Parent/Legal Guardian Relationship Date

WHEELCHAIR SUPPLIER (Please check all of the following statements that apply. If a statement does not apply, please state why they do not apply in the comments section below**)**

☐ I concur with the recommendations made, and I am unaware of any other less costly wheelchairs or options in the market at this time that would meet this recipient's needs.

☐ The recipient ☐ **is** ☐ **is not** a nursing facility resident or awaiting placement to a nursing facility.

☐ The recipient is a nursing facility resident but is awaiting discharge.

☐ To the best of my knowledge, the recipient ☐ **has** ☐ **has not** received, nor is expected to receive, a wheelchair (seating system) from other sources.

☐ To the best of my knowledge, the recipient ☐ **does** ☐ **does not** have insurance or funding sources for this seating system.

☐ The chair being requested ☐ **is** ☐ **is not** a backup seating system to any current mobility system the recipient now has or is expected to obtain.

☐ Any and all components (i.e. cushions, trays, headrests) that can be utilized from the recipient's current wheelchair will be placed on the new wheelchair.

☐ I have visited the recipient's home and have verified that the home may be accessed using this wheelchair (including bedroom, bath, and other living spaces as needed).

☐ I recommend consideration of the equipment changes as listed below:

_____

_____

_____

_____

By signing below, the selected wheelchair vendor acknowledges that the NH Medicaid payment for the wheelchair to the vendor is **inclusive** of the following services: 1. **Delivery** and assembly of the chair; 2. E**xplanation** as to the proper care and preventive maintenance of the chair; 3. **Demonstration** as to the chair's proper operating procedure; and 4. Any necessary **follow-up for training** and/or **adjustments** required for the chair within 30 days following the delivery of the chair.

_____ _____

Signature of DME Vendor Date

_____ _____

Printed Name of DME Vendor Name of agency

MOBILITY EVALUATION FORM:
FORM 272M FFS MOBILITY EVALUATION FORM WHEELCHAIR

The only change made to this form is to cite the rule regarding its use. This form must be filled out pursuant to He-W 571.05(c): Requests for all wheelchairs, scooters, and customized strollers must also include a completed Form 272M, "Mobility Evaluation Form."

Please note that before this form is filled out, it is your responsibility to verify eligibility of the recipient for the Fee-for-Service (FFS) program. That can be done by calling the number on the back of the recipient's Medicaid card; calling Conduent at 886-291-1674; looking directly in the MMIS system; or using the software your office has to access the information.

The first two sections are the Recipient Information and Provider Information and should be filled out accordingly. Fill in all sections of the form by printing your answer to each question. This form should be signed by the wheelchair vendor.

Attach this document, the Physicians order, the Letter of Medical Necessity, and clinical notes supporting the request to the DME Service Authorization Request. Fax all documentation to 603-271-8194. You will receive a fax from the state with the authorization information or a request for more information.